No. 88-1318

Supreme Court, U.S.
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In The

Supreme Court of the United States

October Term, 1988

COMMONWEALTH OF PENNSYLVANIA,

Petitioner,

vs.

KENNETH A. STEIN,

Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF PENNSYLVANIA

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QUESTION PRESENTED FOR REVIEW

Whether the Supreme Court of Pennsylvania was correct in ruling that the due process clause of the Fourteenth Amendment is violated, on void for vagueness grounds, where a criminal defendant is charged, by information, with an unambiguous Medicaid fraud statute but the defendant relies upon an arguably ambiguous medical assistance regulation in order to defend against enumerated Medicaid fraud offenses?

PARTIES TO THE ACTION

The caption of the case contains the names of all the parties.

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II. The Pennsylvania Supreme Court's application of a facial attack, on due process grounds, upon the billing code regulation was error because no First Amendment rights were infringed and a conviction of Medicaid fraud in Pennsylvania requires proof of a culpable mental state. 13

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KENNETH A. STEIN,

Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF PENNSYLVANIA

OPINIONS BELOW

The opinion of the Supreme Court of Pennsylvania is reported as follows: *Commonwealth v. Stein,* ____ Pa. ____, 546 A.2d 36 (1988). The opinion of the Superior Court of Pennsylvania is reported as follows: *Commonwealth v. Stein,* 363 Pa. Super. 410, 526 A.2d 411 (1987). The opinion of the Court of Common Pleas of Philadelphia County is not officially reported. However, the opinion was issued on November 6, 1985 and a true and correct

copy of the opinion is made a part of the appendix, along with the state appellate court opinions in this case.

STATEMENT OF JURISDICTION

The judgment of the Supreme Court of Pennsylvania was entered on August 10, 1988. The Commonwealth's timely filed petition for rehearing was denied by the Supreme Court of Pennsylvania on October 17, 1988. A copy of the Pennsylvania Supreme Court's order denying its petition for rehearing is attached to the appendix.

The Commonwealth believes that this Court has jurisdiction to review rights accorded by a state court pursuant to the state court's interpretation of the due process clause of the Constitution of the United States by writ of certiorari as set forth in 28 U.S.C. § 1257(3).

CONSTITUTIONAL PROVISIONS AND STATUTES INVOLVED

United States Constitution, Amendment 14, Section 1 as follows:

> All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

Fraud and Abuse Control provisions of the Public Welfare Code, 62 P.S. §§ 1407(a)(1), (a)(4), and (a)(9) (pocket part) as follows:

> Section 1407. Provider prohibited acts, criminal penalties and civil remedies.
>
> (a) It shall be unlawful for any person to:
>
> (1) . . .Knowingly submit false information, for the purpose of obtaining greater compensation than that to which he is legally entitled for furnishing services or merchandise under medical assistance . . . .
>
> (4) Submit a claim for services . . . which w(as) not rendered to a recipient.
>
> (9) Submit a claim for a service . . . which was not rendered by the provider.

STATEMENT OF THE CASE

This case involved a prosecution by the Office of Attorney General of the Commonwealth of Pennsylvania of a podiatric physician for Medicaid fraud. The gravamen of the offense was that Dr. Stein (Stein) submitted bills for office visits for minor patients on medical assistance, notwithstanding the fact that these children were never seen by Stein. Stein's position was that he submitted an invoice identifying the service provided utilizing a medical assistance billing code designated as 90005. The terminology used to define billing code 90005 at the relevant time was: "Office visit, brief examination, evaluation and/or treatment".

The defense offered by Stein was that although he did not see or examine the patient, he nevertheless did an "evaluation" because he looked at the patient's medical file and he rendered "treatment" because he wrote a prescription for an orthopedic shoe for the patient even though Stein did not contend that he saw the patient's foot at the time he gave the prescription to the patient's sibling or parent. The sibling or parent would routinely call Stein's office in order to pick up these prescriptions for the minor patient in question.

Stein was prosecuted, alternatively, under three separate sections of a criminal statute prohibiting fraud and abuse pertaining to the Pennsylvania Medical Assistance Program. He was charged with submitting false information for the purpose of obtaining greater compensation than that to which he was legally entitled for furnishing services under the Medicaid program, for submitting claims for services which were not rendered to a recipient, and for submitting claims for services which were not rendered by him as a provider. *See* 62 P.S. §§ 1407(a)(1), (a)(4), (a)(9) (pocket part), *supra*.

Billing code 90005 is a part of the regulations that the Pennsylvania Department of Public Welfare is authorized to promulgate pursuant to the Fraud and Abuse Control Provisions of the Public Welfare Code. *See* 62 P.S. § 1410 (pocket part). Among the numerous Department of Public Welfare regulations, billing code 90005 is perhaps one of hundreds of such billing codes contained in the medical assistance fee schedule, which is an integral part of the Medicaid regulations. *See* 55 Pa. Code Chapter 1150, Medical Assistance Fee Schedule.

The trial judge dismissed 24 counts on three separate informations prior to verdict, and nine counts on three separate informations prior to trial. The Commonwealth filed an appeal on all dismissed counts, but had to discontinue its appeal on the

24 pre-verdict counts as a result of this Court's decision in *Smalis v. Pennsylvania,* 476 U.S. 140, 106 S. Ct. 1745, 90 L. Ed. 2d 116 (1986).

This petition for certiorari, then, concerns only the disposition of the constitutional question relating to the nine-count pre-trial dismissal. The trial judge, in essence, found that the terminology of billing code 90005 was ambiguous, and for that reason dismissed the nine counts in issue. The Commonwealth sought review in the Superior Court of Pennsylvania. The Superior Court of Pennsylvania reversed the trial court finding no particular ambiguity in the billing code. *Commonwealth v. Stein,* at 526 A.2d 413, n. 3. Further, the Superior Court ruled that any ambiguity or confusion as to Stein's interpretation of the Medicaid billing code was relevant to a defense on the merits to the charges, which could be asserted by him at trial and would not serve as a basis to quash pre-trial a facially valid information, charging Stein with Medicaid fraud as defined by statute. *Id.* at 526 A.2d 4.

The Supreme Court of Pennsylvania granted Stein's petition for discretionary review and reversed the Superior Court ruling that the regulation was facially ambiguous, and therefore, the trial court was correct to dismiss the nine counts pre-trial in that Stein was denied due process of law. This determination was made by the Supreme Court of Pennsylvania as a matter of federal constitutional law; no justification for the opinion rests upon the state constitutional provision embodying the federal due process clause. *See* Pa. Const., Art. I, Sec. 9 (pocket part).

In passing upon the federal constitutional question of due process, the majority opinion, authored by Justice Papadakos, states the following:

> As a matter of due process, a criminal statute that fails to give a person of ordinary intelligence

> fair notice that his contemplated conduct is forbidden by the statute or that is so indefinite that it encourages arbitrary and erratic arrests and convictions is void for vagueness. *Colautti v. Franklin,* 439 U.S. 379 at 390, 99 S.Ct. 675, at 683, 58 L.Ed.2d 596 (1979). Whether a statute (or, as here, an administrative regulation) is vague or ambiguous is a matter of law to be determined from the face of the statute or regulation itself.

Commonwealth v. Stein, supra at 546 A.2d 40.

The above decision was issued on August 10, 1988.

PRESERVATION OF ISSUE

The Commonwealth filed a timely petition for rehearing with the Pennsylvania Supreme Court taking issue with that court's finding of a constitutional due process violation on vagueness grounds. The Commonwealth's petition for rehearing was denied by the Supreme Court of Pennsylvania on October 17, 1988. In its petition for rehearing the Commonwealth urged the Pennsylvania Supreme Court to re-examine its determination that a due process violation had occurred. This federal question was timely raised for the first time in the Commonwealth's petition for rehearing in response to the Supreme Court's reversal of the Superior Court opinion which ruled that an asserted ambiguity does not prohibit criminal prosecution of facially valid informations charging Medicaid fraud.

In numerous and varied places in its petition for rehearing, the federal question sought to be reviewed was raised and presented to the Pennsylvania Supreme Court in the following pages of petitioner's timely petition for rehearing:

> This court has reversed the Superior Court without reaching the Commonwealth's argument as to waiver and has essentially concluded that a judicially determined ambiguity contained in a procedure code regulation can serve to quash a facially valid information on due process grounds. (p.2)

> It is respectfully suhmitted that reargument should be granted, on the merits, because a due process violation on constitutional vagueness grounds cannot exist when the criminal statute under which the defendant is prosecuted is not, itself, unconstitutionally vague. (p.3)

> The decision by this Court to quash informations, because of a constitutional due process violation on vagueness grounds, has never been previously addressed by the trial court, the parties, or the Superior Court. The dismissal of this prosecution by the Court, on this basis, was erroneous as a matter of law for the reasons previously set forth in this application. At a minimum and as a matter of fairness, the parties should have an opportunity to submit briefs on the issue of the applicability of the void for vagueness doctrine relied upon in this Court's plurality and concurring opinions. (pp.9-10)

The Supreme Court of Pennsylvania passed upon this question by denying the Commonwealth's petition for reargument on October 17, 1988.

REASONS FOR GRANTING THE WRIT

I.

ARGUABLE AMBIGUITY IN A MEDICAID BILLING CODE DOES NOT VIOLATE DUE PROCESS SO LONG AS THE CRIMINAL STATUTE ON WHICH THE DEFENDANT IS PROSECUTED IS NOT AMBIGUOUS AND PLAINLY PROSCRIBES THE CONDUCT MADE CRIMINAL.

Stein's factual and legal contentions that billing code 90005 fits the service he provided were addressed by Justice Kennedy when he sat as a Judge on the Ninth Circuit Court of Appeals in connection with a Hawaiian physician's appeal from his conviction for Medicaid fraud. *See United States v. Larm,* 824 F.2d 780 (9th Cir. 1987). In that case issues were raised relating to the sufficiency of the evidence and whether the convictions violated due process on ambiguity or vagueness grounds.

First, Dr. Larm, like Stein, contended on appeal that his conduct fit the definition of an office visit applicable to him under billing code 90040 in seeking to have his conviction of not providing services on office visit counts reversed. In rejecting this contention, Justice Kennedy stated the following:

> The Larms' most serious attack on the office visit counts is that the statements were not false. It is undisputed that in each of the office visit counts (and the administration counts) the Larms used billing code 90040. Code 90040 is defined as a "(b)rief examination, evaluation, and/or treatment, same or new illness." This is further defined as "includ(ing) a brief or interval history, examination, discussion of finding and/or rendering of service." The treatment given in each

> case was a routine allergy shot administered by a nurse, when Dr. Larm was not in the office. The Larms argue that this treatment fits within the meaning of the definition, and the evidence of falsity was thus insufficient. Two factors converged to convince us of the sufficiency of the evidence of falsity. The first is, that code 90030, appearing on the same page as code 90040, is defined as follows: "minimal service: injections, minimal dressings, etc., not necessarily requiring the presence of a physician." This code fits exactly the service rendered in the office visit counts. Since each code corresponds to a different billing amount, it is clear that these codes are intended to be exclusive of each other. The snug fit between code 90030 and the service actually rendered forecloses any argument that code 90040 was the correct code. The second factor is that an HMSA representative testified that he twice informed the Larms that a code 90040 billing required the physician's presence. Although the Larms attacked the credibility of this testimony, the jury was entitled to believe the HMSA representative. The evidence of falsity on the office visit counts was sufficient.

Id. at 782-783.

Although the same factors are not coincident in the case at bar, the reasoning is directly analagous to this case for which review is sought.

Billing code 90005 contains the same terminology as the billing code in the *Larm* case. Billing code 90005 appears on the same page as another code defining "home visit codes", 90110 and

90113. Billing code 90110 reads as follows: "Home visit, brief examination, evaluation, and/or treatment. Note: Payment will not be made for services for more than two persons during a *visit to a patient's home*, no matter how many others are *seen*." Billing code 90111 reads: "Home visit - additional fee for the first person *seen* in a patient's home or in a nursing facility during the call" (emphasis added).

The above billing code regulations were published in the Pennsylvania Bulletin on May 17, 1980, and were applicable to the office visits billed by Stein in this case. Furthermore, it was established on the record below and not disputed that providers were sent copies of all Department of Public Welfare regulations. The language of the above promulgated regulations is found in 10 Pa. Bull. 1985 and is fully reproduced in the appendix to this petition.

A second factor that militates against any confusion on Stein's part that his conduct did not justify billing under this code was the fact that he testified on the record (R141, 145, 146) that when a member from the patient's family would come to pick up an orthopedic shoe prescription, he would tell that family member that he preferred to see the patient.

More importantly, the *Larm* decision rejected the very claim of a federal due process violation found to exist by the Pennsylvania Supreme Court in the instant case. Justice Kennedy analyzed the due process claim as follows:

> The Larms make a due process challenge to their conviction. They point out that the code book was never adopted as a rule in conformance with the Hawaii Administrative Procedure Act. See, Haw. Rev. Stat. §§ 91-3 to 91-15. They argue they lacked fair notice that their conduct was illegal. This

> argument is without merit. The Larms were prosecuted under 42 U.S.C. Sec. 1396h (a)(1), not the billing codes. The statute gives fair notice of the proscribed conduct . . . It is the statute that must give sufficient notice of the proscribed conduct, both through adequate promulgation and definiteness in its language. See, *United States v. Harriss,* 347 U.S. 612, 617, 74 S.Ct. 808, 811, 98 L.Ed. 989 (1954). Here, the statute forbids knowingly false material statements, terms that are adequate to inform the ordinary person of its bounds. Any attack on the billing codes which form the factual backdrop that made the statements false is ultimately an attack on the sufficiency of the evidence. See, id. at 618, 74 S.Ct. at 812 (a statute is not void for vagueness, despite the existence of borderline cases of applicability).

Id. at 784.

If the Pennsylvania Supreme Court had correctly decided the due process question, the same result should have obtained in Stein's case and the Commonwealth should have been permitted to try him on the office visit counts dismissed pre-trial. This Court's decision in *United States v. Harriss,* 347 U.S. 612, 74 S. Ct. 808, 98 L. Ed. 989 (1954) on what constitutes a denial of due process on constitutional vagueness grounds was cited by the petitioner at the first opportunity in its petition for a rehearing before the Pennsylvania Supreme Court.

As in the *Larm* decision, the money involved in the instant case that was alleged to have been stolen is small. The total sum initially charged was slightly more than $600 and less than $800. This amount was then reduced to less than $100 after the Commonwealth discontinued its appeal pursuant to this Court's

decision in *Smalis v. Pennsylvania, supra.* However, the consequences as a whole for the administration of the medical assistance program in Pennsylvania are enormous. Almost half of the Medicaid funds in Pennsylvania in 1985 were received from federal funds. The federal appropriation for that year was $203,000,000 for a total state and federal appropriation of $432,000,000. There is no question that the cost of fraud to our nation's Medicaid system for the poor and its Medicare system for the elderly has been severe. Estimates of loss, due to fraud run to 10% of total federal funds allocated to these programs each year. *Mayers v. U.S. Department of Health & Human Services,* 806 F.2d 995, 999 (11th Cir. 1986); *see* Kusserow, *Civil Monetary Penalties Law of 1981: A New Effort to Confront Fraud and Abuse in Federal Health Care Programs,* 58 Notre Dame L. Rev. 985, 987 (1983).

Between 1965 and 1983 national health care expenditures under Medicare and Medicaid increased from $43 billion to $343 billion annually. *See* McDowell, *The Medicare-Medicaid Anti-Fraud and Abuse Amendments: Their Impact on the Present Health Care System,* 36 Emory L.J. 691, 699, n. 42 (Spring 1987). A massive crisis exists in this area and a definite component of that crisis is fraud and abuse. *See* Rosenblatt, *Health Care Reform and Administrative Law: A Structural Approach,* 88 Yale L.J. 243, 244-45 (1978).

The United States Attorney's Office does not generally prosecute Medicaid fraud, due to a backlog of cases, lack of sufficient expertise in Medicaid law, not warranting the investment of time and effort necessary to acquire the expertise to prosecute on an insufficient number of counts or amount of money to warrant criminal proceedings. *Kusserow, supra* at 989. Thus, the bulk of the responsibility for Medicaid fraud prosecutions, of necessity, devolves upon state, rather than federal prosecutors.

Along with other reasons expressed in this petition and due to the staggering economic consequences that may result in Pennsylvania if the Supreme Court's decision is permitted to stand, it is urged that this Court accept jurisdiction by certiorari to review, what the Commonwealth respectfully submits, is an erroneous interpretation of the due process clause by the Pennsylvania Supreme Court.

If this decision is allowed to stand in its present posture, the effective prosecution of Medicaid fraud will be severely hampered in the Commonwealth of Pennsylvania. In almost any Medicaid fraud prosecution, a defendant health care provider can point to an arguably ambiguous social service regulation and forcefully rely upon the State Supreme Court precedent of *Stein* to convince a trial judge that the prosecution should be dismissed pre-trial before there is any opportunity for the fact finder, be it judge or jury, to render a decision in the case on the merits.

II.

THE PENNSYLVANIA SUPREME COURT'S APPLICATION OF A FACIAL ATTACK, ON DUE PROCESS GROUNDS, UPON THE BILLING CODE REGULATION WAS ERROR BECAUSE NO FIRST AMENDMENT RIGHTS WERE INFRINGED AND A CONVICTION OF MEDICAID FRAUD IN PENNSYLVANIA REQUIRES PROOF OF A CULPABLE MENTAL STATE.

The Supreme Court of Pennsylvania erroneously applied a stricter standard to the due process question when it judged the billing code regulation facially. A stricter facial analysis is only appropriate where first amendment freedoms are in danger. *Smith v. California,* 361 U.S. 147, 80 S. Ct. 215, 4 L. Ed. 2d 205 (1959). Otherwise, vagueness challenges to statutes which do not involve first amendment freedoms must be examined in light of the facts of the case at hand. *Hoffman Estates v. Flipside, Hoffman Estates,*

Inc., 455 U.S. 489, 102 S. Ct. 1186, 71 L. Ed. 2d 362 (1982). It is clear that the Pennsylvania Supreme Court employed such an improper due process analysis when that court stated:

> Whether a statute (or, as here, an administrative regulation) is vague or ambiguous is a matter of law to be determined from the face of the statute or regulation itself. It does not depend on a particular defendant's motive or intent, what a particular defendant thought the rule or statute meant or whether or not the defendant accurately guessed what the draftsman had actually intended.

Id. at 546 A.2d 40.

Contrary to the above pronouncement, it is submitted that where the statute requires proof of a type of *mens rea* (as does the Pennsylvania statute) there is no basis for a finding of vagueness. *Colautti v. Franklin, supra* at 439 U.S. 395. Consequently, the Pennsylvania Supreme Court misapplied the *Colautti* decision to reach the result that it did in this case.

The Pennsylvania Supreme Court, in finding a due process violation in this case, failed to note that a vagueness challenge must be examined according to whether fair notice was given to a person of ordinary intelligence in the class of Stein as a podiatric physician of ordinary intelligence. *Cf., American Communications Association v. Douds,* 339 U.S. 382, 412, 70 S.Ct. 674, 691, 94 L.Ed. 925 (1949). Since neither the Pennsylvania Medicaid fraud statute nor the billing code regulation punishes good faith errors by Medicaid providers, no due process violation, on the basis of unconstitutional vagueness, existed in this case. *Harris v. McRae,* 448 U.S. 297, 311, n. 17, 100 S. Ct. 2671, 2685, n. 17, 65 L. Ed. 2d, 784, 801, n. 17 (1980).

CONCLUSION

The criteria in Rule 17 for granting certiorari have been met in this case. In comparing the relevant decisions on this factual and legal issue, it appears that: (1) A federal Court of Appeals has decided a federal question of due process in a way in conflict with a state court of last resort; (2) A state court of last resort has decided a federal question of due process in a way in conflict with a decision of a federal Court of Appeals; and (3) A state court has decided a federal question of due process in a way in conflict with applicable decisions of this Court in *United States v. Harriss, supra* and *Harris v. McCrae, supra.*

For all of the above reasons set forth in this petition, the petitioner, the Commonwealth of Pennsylvania, respectfully requests that its petition for a writ of certiorari be granted and that the judgment of the Supreme Court of Pennsylvania be reversed.

Respectfully submitted,

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Attorney General
Attorneys for Petitioner

APPENDIX A — ORDER OF THE SUPREME COURT OF PENNSYLVANIA DATED OCTOBER 17, 1988

SUPREME COURT OF PENNSYLVANIA
EASTERN DISTRICT

October 21, 1988

Ronald T. Williamson, Esquire
Deputy Attorney General
OFFICE OF ATTORNEY GENERAL
2490 Boulevard of the Generals
Norristown, Pennsylvania 19403

RE: Commonwealth of Pennsylvania v. Kenneth A. Stein, Appellant
No. 156 E.D. Appeal Docket 1987

Dear Mr. Williamson:

This is to advise you that the following Order has been endorsed on your Application for Reargument En Banc, filed in the above captioned matter:

"October 17, 1988.

Petition Denied.

Per Curiam."

Very truly yours,

PATRICK TASSOS
Deputy Prothonotary

/aw
cc: Richard Max Bockol, Esquire

APPENDIX B — OPINION OF THE SUPREME COURT OF PENNSYLVANIA DECIDED AUGUST 10, 1988

COMMONWEALTH of Pennsylvania,

Appellee,

v.

Kenneth A. STEIN,

Appellant.

Supreme Court of Pennsylvania.

Argued April 13, 1988.

Decided Aug. 10, 1988.

Richard Max Bockol, for appellant.

Ronald T. Williamson, Deputy Atty. Gen., for appellee.

Before NIX, C.J., and LARSEN, FLAHERTY, McDERMOTT, ZAPPALA, PAPADAKOS and STOUT, JJ.

OPINION ANNOUNCING THE JUDGMENT OF THE COURT

PAPADAKOS, Justice.

This case concerns the question of whether the Court of Common Pleas of Philadelphia County (per Judge William Porter) was correct in quashing 27 counts of Medicaid fraud brought against Appellant. The Superior Court concluded that the pre-

trial order quashing these counts was in error. For the reasons set forth below, we reverse and reinstate the order of the Court of Common Pleas.

The facts in this case are as follows. Appellant, Dr. Kenneth A. Stein, D.P.M., is a licensed podiatrist. At the time of his arrest in the instant case, on September 22, 1983, Appellant was a registered health care provider with the Commonwealth's Department of Public Welfare (DPW), which is the state agency that administers our Medical Assistance Program. Appellant was paid by the Commonwealth for podiatric services that he billed to the Medical Assistance Program. Appellant was arrested and charged with 99 counts of Medicaid fraud as set forth in three separate bills of information. Informations were filed against Appellant charging him with 33 violations of each of three different sections of the Fraud and Abuse Control provisions of the Public Welfare Code, 62 P.S. §§1407(a)(1), (a)(4) and (a)(9).[1]

---

1. 62 P.S. § 1407 provides, in pertinent part, as follows:

> § 1407. Provided prohibited acts, criminal penalties and civil remedies
>
> (a) It shall be unlawful for any person to:
>
> (1) Knowingly or intentionally present for allowance or payment any false or fraudulent claim or cost report for furnishing services or merchandise under medical assistance, or to knowingly present for allowance or payment any claim or cost report for medically unnecessary services or merchandise under medical assistance, or to knowingly submit false information, for the purpose of obtaining greater compensation than that to which he is legally entitled for furnishing services or merchandise under medical assistance,

(Cont'd)

Appendix B

Essentially, Appellant was charged with billing DPW for services which, DPW charged, did not qualify for payments to Appellant as a medical provider. The disputed billings were for some 33 renewals of prescriptions for orthopaedic shoes for the children of three qualified medical assistance recipients. It is admitted that Appellant did not have face-to-face encounters with the minor children for whom he wrote the renewal prescriptions in this case. Rather, Appellant was contacted by the child's mother or elder sibling who indicated that there was a need for another prescription for orthopaedic shoes. Appellant claims that all of the children involved were from large families, that they were either at school or ill and so could not come to the doctor's office, and that no prescriptions were renewed until after Appellant had actually seen the child's mother or sibling at his office. In any event, it is conceded that Appellant consulted each child's office file and then wrote out the prescription requested. He subsequently billed DPW under Fee Schedule, Procedure Code #90005.

The Commonwealth contends that the renewal of such prescriptions in this manner is not compensible because payments

---

(Cont'd)

> or to knowingly submit false information for the purposes of obtaining authorization or furnishing services or merchandise under medical assistance.
>
> . . . . .
>
> (4) Submit a claim for services, supplies or equipment which were not rendered to a recipient.
>
> . . . . .
>
> (9) Submit a claim for a service or item which was not rendered by the provider.

for such services are not authorized by DPW regulations. It further argues that by allegedly billing for "office visits," Appellant had not rendered the type of service which must be rendered in order for a service to qualify for payment as an "office visit" under those regulations.

The DPW manual sets forth a Fee Schedule (R., 7a). Immediately prior to setting forth the Fee Schedule, there is a paragraph included under "General Provisions" which provides as follows:

> Providers shall include the appropriate procedure codes and terminology on all claims submitted for payment. The following fee schedules are all inclusive; therefore, only those services identified by a procedure code are covered by the Medical Assistance Program.

Immediately following is the Fee Schedule itself. "Procedure Code" #90005 is the first code number listed. The "terminology" for which it is applicable is stated as follows:

> Office visit, brief examination, evaluation and/or treatement.

Appellant argues that the real nature of the offenses for which he is being charged is that he improperly reported code number 90005 on his billing statement for the services rendered (as described above).

Effective January 1, 1983, the DPW manual was amended to include a "definitions" section. "Visit" is now defined as a "face-to-face encounter between a patient and a practitioner,

except as otherwise stated in the specific Medical Assistance provider chapters, for the purpose of furnishing medically necessary medical services." (R., 8a).

Appellant filed a "Motion for Accelerated Rehabilitative Disposition and/or Motion to Strike the Information" with the Court of Common Pleas with respect to all 99 counts. Judge Porter treated this as a motion to quash (Trial court opinion, p. 1; R., 9a, n. 1) (see Pa.R.Crim.P. 306, and the comments thereto), and, as such, the motion was granted in part on November 6, 1985. Judge Porter quashed 9 counts on each of the three informations (27 counts in all). Each of the 27 counts which were quashed dealt with a billing for a prescription that had been written *prior* to January 1, 1983, the effective date of the amendments to the DPW manual defining a "visit" as a face-to-face encounter. Judge Porter concluded that the alleged offenses involved in the situations where the events occurred before the "face-to-face encounter" definition of January 1, 1983 became effective, were not offenses for which Appellant should be put on trial. The Court reasoned that the Fee Schedule—Procedure Code was subject to an ambiguous interpretation by a medical provider before the "face-to-face encounter" requirement was promulgated. The Court found that prior to January 1, 1983, Appellant did receive an office visit or office contact by members of the patients' families and that he did examine the patients' files or charts, and prescribed shoes for the patients' conditions. While conceding that it might be argued that the term "brief examination" might mean a brief examination of the patient (and not of the patient's file), and that the term "evaluation" might suggest an evaluation of the patient and not an evaluation or his or her file, the Court concluded that if only one interpretation could be gleaned from the pre-January 1, 1983 regulations, there would have been no need to add the "face-to-face encounter" definition of "visit" by the

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January 1, 1983 amendment. Therefore, the Court was satisfied that enough of an ambiguity existed in the definition of "office visit" before the January 1, 1983, revision so as to create a reasonable basis for misinterpretation of the term "office visit" prior to the issuance of the revised definition of the term "visit."

Immediately following Judge Porter's partial grant of the motion to quash, Appellant elected to waive his right to a jury trial and proceed to a non-jury trial before Judge Porter that same day on the remaining 72 counts, all of which related to prescriptions written after January 1, 1983. At the conclusion of the Commonwealth's case on November 7, 1985 (two days later), Judge Porter sustained Appellant's demurrer to 60 counts charged in the informations. Appellant was found not guilty on the remaining 12 counts. The Commonwealth promptly appealed both Judge Porter's order quashing 27 counts (relating to prescriptions written before January 1, 1983); and Judge Porter's order sustaining the demurrer to 60 counts. The two appeals were consolidated. The Commmonwealth later discontinued its appeal with respect to the grant of the demurrer to the 60 counts on the basis of *Smalis v. Pennsylvania,* 476 U.S. 140, 106 S.Ct. 1745, 90 L.Ed.2d 116 (1986), which prohibits an appeal from the grant of a demurrer.

The Commonwealth's appeal to the Superior Court proceeded on the sole issue of the propriety of Judge Porter quashing the 27 counts relating to prescriptions written before January 1, 1983. The Superior Court reversed and remanded for retrial, 363 Pa.Super 410, 526 A.2d 411 (1987). Judge Cavanaugh's opinion reasoned that any ambiguity or confusion as to the Appellant's interpretation of the Fee Schedule was more properly a matter relevant to Appellant's defense and that the matter could be asserted at trial; but that the asserted ambiguity or confusion could

not serve as a basis to quash facially valid informations. In other words, the Superior Court concluded that the information established a minimum *prima facie* case such that Appellant was required to stand trial.

We granted Appellant's petition for allowance of appeal for two reasons. First, Appellant's argument concerning the language of the Fee Schedule, and its subsequent amendment, is patently troublesome and certainly suggests the existence of an ambiguity and a reasonable basis for misinterpretation. Second, Judge Porter's ruling on the motion to quash was entered shortly before Appellant proceeded to trial before him on the other related charges. As Appellant persuasively argued one might very reaonably conclude (especially in light of the subsequent grant of the demurrer) that Judge Porter's initial grant of the motion to quash was, in effect, a statement by him that, by reason of the language of the Fee Schedule, he could not find Appellant guilty. Therefore, allowing the Commonwealth to try Appellant on these charges might well violate his double jeopardy rights under these circumstances, particularly in light of *Smalis v. Pennsylvania, supra.* Appellant's double jeopardy argument is bolstered by the fact that proof of the charges which were quashed by Judge Porter might well include elements identical to those with respect to which Appellant has already been acquitted (or with respect to which demurrers have been sustained). Fairly difficult collateral estoppel issues are lurking, therefore, in Appellant's double jeopardy claims. See, *e.g., Commonwealth v. Grazier,* 481 Pa. 622, 393 A.2d 335 (1978). We do not reach Appellant's double jeopardy claims, however, because we have concluded that Judge Porter's decision to quash the 27 counts at issue was correct. Hence, the Superior Court's remand for a re-trial must be reversed. The decision to quash was correct because the DPW Fee Schedule and regulations as they existed prior to

January 1, 1983, were vague and ambiguous as applied to the facts of this case.

As a matter of due process, a criminal statute that fails to give a person of ordinary intelligence fair notice that his contemplated conduct is forbidden by the statute or that is so indefinite that it encourages arbitrary and erratic arrests and convictions is void for vagueness. *Colautti v. Franklin,* 439 U.S. 379, at 390, 99 S.Ct. 675, at 683, 58 L.Ed.2d 596 (1979). Whether a statute (or, as here, an administrative regulation) is vague or ambiguous is a matter of law to be determined from the face of the statute or regulation itself. It does not depend on a particular defendant's motive or intent, what a particular defendant thought the rule or statute meant, or whether or not the defendant accurately guessed what the draftsman had actually intended. Special care must be taken by our courts when criminal penalties may be imposed, as here, for violations of an administrative rule or regulation. The administrative rules or regulations must be written so that they fill in the details of what is otherwise a broad statutory proscription against wrongdoing. They must describe with particularity what is permitted and what is forbidden. They must create standards that eliminate vagueness and uncertainty, not create it. See, K.C. Davis, Discretionary Justice 58 (1969); and see also, Schwartz, Administrative Law § 29 (1976).

Procedure Code #90005 is to be used by a participating doctor to claim reimbursement for an "office visit, brief examination, evaluation and/or treatment." (R. 7a). The four terms are used disjunctively. Nothing about the terms "brief examination" or "evaluation" necessarily indicates that a face-to-face office visit is an essential pre-requisite to a charge for reimbursement under either of these categories. Indeed, it would be an unimaginative person who would contend that the English language is so dull

and primative that either term is susceptible of but one rigid and narrow connotation. DPW conceded that even its use of the term "office visit" was vague and subject to misinterpretation when it amended its regulations effective January 1, 1983, to define "visit" as necessitating a face-to-face encounter. In short, we hold that these regulations, as they existed prior to January 1, 1983, were too vague and indefinite to indicate to Appellant, or to anyone else, that renewing a prescription without actually seeing the patient in a face-to-face encounter, but after having examined the patient's file, was not compensible; and that they were certainly too vague and indefinite to indicate that the use of Procedure Code #90005 to make a claim for compensation for such services constituted the crime of fraud. Judge Porter correctly quashed the 27 counts at issue.

Reversed.

FLAHERTY, J., files a concurring opinion in which STOUT, J., joins.

NIX, C.J., and McDERMOTT, J., file a dissenting opinion.

FLAHERTY, Justice, concurring.

I cannot subscribe to the view that the term "office visit" is ambiguous or that it could mean anything other than a face-to-face encounter between a practitioner* and his patient in the practitioner's office. This is clear whether or not the term was defined in the DPW manual. The mere fact that a definitions section was introduced in the manual on January 1, 1983, does

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* Appellant is not a medical doctor, but a podiatrist, a practitioner who treats the human foot.

not mean that the term was ambiguous prior to that time.

I agree, however, that the procedure code, 90005, is too vague and ambiguous to form the basis of a criminal prosecution. Appellant billed for services performed under code 90005, believing that permissible services included "evaluations." The department's definition of code 90005 is "office visit, brief examination, evaluation and/or treatment." Reading the definition of code 90005 in comparison with other procedure codes and their definitions, it appears that code 90005 covers office visits incorporating a brief examination, evaluation or treatment. If the definition had been punctuated properly, it might have read "office visit: brief examination, evaluation or treatment." This is the meaning ascribed by the trial court and by Superior Court, and other codes indicate that this is what the DPW manual meant. Examples are: 90110, explained as "Home visit, brief examination evaluation and/or treatment"; 90300, defined as "Skilled nursing facility visit, brief examination"; and 90301, explained as "Intermediate care facility visit, brief examination." Thus, it appears that the manual intended to restrict the use of code 90005 to office visits during which the practitioner conducted a brief examination, evaluation or treatment of his patient.

It is nevertheless grammatically reasonable, albeit barely, to interpret procedure code 90005 as including any one of four different kinds of procedures: treatments, evaluations, brief examinations, or office visits. The behavior of Dr. Stein in this case might conceivably be viewed as some sort of evaluation, and under the wording of the definition for procedure code 90005, his claim for reimbursement cannot be viewed as criminally sanctionable.

In algebraic terms, one could understand code 90005 to

require A, an office visit, combined with either B, a brief examination, C, an evaluation, or D, treatment. In other words, 90005 would require A + B, A + C, or A + D. The definition given in the manual, however, can be read to permit A or B or C or D, any one of which would satisfy the requirements of code 90005, without the need for an office visit.

Although I think the term "office visit" itself is quite clear, the definition of procedure code 90005 is sufficiently ambiguous that it cannot support the criminal charges brought against Dr. Stein, I therefore concur in the result reached by the majority.

STOUT, J., joins this concurring opinion.

NIX, Chief Justice, dissenting.

Socialized medical care is a concept that has been resisted in the United States for years. While I concede that there are legitimate concerns which would cause a prudent person to refrain from hastily pursuing this avenue of health care provision, I fear that the cost of medical care is rising at such a rate that some feasible alternative must be developed. At this stage of our civilization, where medical science has made significant advances in extending the length and improving the quality of human life, it should be our highest priority to assure that all people, regardless of their financial capabilities, have unfettered access to adequate medical care. Title XIX of the Social Security Act, 42 U.S.C. §§ 1396-1396s, which provides money to states to fund medical assistance programs, is designed to assist in achieving this goal.

The majority today has engaged in sophistry in concluding that the regulations existing prior to January 1, 1983, were too vague to allow appellant to be held accountable for his impropriety.

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Section 1407 of the Public Welfare Code, 62 P.S. § 1407, prohibits providers such as appellant from presenting false or fraudulent claims to the Department of Public Welfare (D.P.W.) for payment. Clearly this statute is designed to preserve the integrity of programs such as the Medical Assistance Program so that the medically needy may avail themselves of necessary medical care.[1] Where the regulations are not without ambiguity, the provider should err on the side of declining payment so as not to deplete the limited resources allocated to the Medical Assistance Program. I would therefore encourage a strict construction of all D.P.W. regulations which permit providers to seek reimbursement for their services, so as to further the goal of adequate health care for all people.

I would hold that the informations filed against appellant, being valid on their face and proper under a strict construction of the relevant D.P.W. regulation, were errroneously quashed prior to trial by the court of common pleas. I would remand the case for trial.

McDERMOTT, Justice, dissenting.

The appellant, a podiatrist, would appear to have sufficient grammatical skills to know that one cannot evaluate a patient by talking to his mother or sister. The need for a colon to make clear what every one knows is the poorest of medical practice, evaluation without seeing a patient, is total nonsense.

I agree with the Superior Court that there was a *prima facie* case, and the appellant should tell his story to a jury. Therefore,

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1. In the introductory paragraph of Act of 1980, July 10, P.L. 493, No. 105, which preceded section 1407, the General Assembly declared that "[i]t is in the public interest that medical assistance services be administered and regulated in a way that will ensure that public funds will be properly expended for essential services to medically needy persons."

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I would affirm the order of the Superior Court.

APPENDIX C—OPINION OF THE SUPERIOR COURT OF PENNSYLVANIA FILED MAY 26, 1987

COMMONWEALTH of Pennsylvania,

Appellant,

v.

Kenneth STEIN,

Superior Court of Pennsylvania.

Argued Oct. 17, 1986.

Filed May 26, 1987.

Ronald T. Williamson, Deputy Atty. Gen. Norristown, for Com., appellant.

Richard M. Bockol, Philadelphia, for appellee.

Before CAVANAUGH, MONTEMURO and BECK, JJ.

CAVANAUGH, Judge:

This action began in 1983 when appellee, a licensed podiatrist, was charged with over 99 counts of Medicaid fraud.[1] The Commonwealth charged appellee with billing the Department of Public Welfare for several podiatric office visits for the sum of Six Dollars ($6.00) each, when in fact the patient had never visited appellee's office. The disputed billings in this case involved

1. Appellee was indicted under 62 Pa.Stat. Ann. §§ 1407(a)(1), (a)(4) and (a)(9). (Purdon 1986 Cumulative Annual Pocket Part.)

renewals of prescriptions, over the telephone, for orthopedic shoes for the children of three qualified medical assistance recipients.[2] Prior to trial, appellee filed a motion entitled "Motion for Accelerated Rehabilitative Disposition and/or Motion to Strike Information" which the trial court treated as a motion to quash. The trial court granted in part appellee's motion dismissing 27 of 99 counts against him. The Commonwealth proceeded to trial on the remaining counts. At the conclusion of the Commonwealth's case, the lower court sustained appellee's demurrer to 60 counts against him. The court later found appellee not guilty on the remaining 12 counts.

The Commonwealth appealed the lower court's orders quashing 27 counts (3015 Phl, 85) and sustaining appellee's demurrer to 60 counts (3016 Phl, 85). These appeals were consolidated. The Commonwealth later discontinued its appeal at 3016 Phl, 85 following the U.S. Supreme Court's decision in *Smalis v. Pennsylvania,* 476 U.S. 140, 106 S.Ct. 1745, 90 L.Ed.2d 116 (1986). In *Smalis,* the U.S. Supreme Court held that a grant of a demurrer to an accused cannot be appealed where reversal would lead to further trial proceedings thereby implicating the double jeopardy clause. Thus, appellant brings one issue before this court: whether the lower court committed reversible error in granting appellee's motion to quash 27 counts against him. We reverse.

The Commonwealth argues that the lower court abused its discretion when it granted in part appellee's motion to quash. It argues that the informations in question were not facially

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2. A review of the record discloses that appellee, on thirty-three occasions, billed the Department of Public Welfare for an "office visit" (Procedure Code #90005) from a member of one of these families.

defective and were not otherwise defective so as to prohibit prosecution. Appellant further argues that the lower court legally erred when it granted the motion as it based its decision on an assessment of the evidence against appellee and not upon a determination of the per se validity of the informations.

We first recognize that the decision to grant or deny a motion to quash is within the sound discretion of the trial judge whose decision will be reversed on appeal only where there has been a clear abuse of discretion. *Commonwealth v. Niemetz,* 282 Pa.Super. 431, 422 A.2d 1369 (1980); *see also Commonwealth v. Hackney,* 117 Pa.Super. 519, 178 A.417 (1935). We have also stated:

> *A Motion to Quash may be used to raise defects apparent on the face of the information or other defects that would prohibit prosecution.* A Motion to Quash an information is neither a guilt determining procedure nor a pre-trial means for determining the sufficiency of the Commonwealth's evidence. (Citations omitted) (Emphasis added.)

Commonwealth v. Meoli, 307 Pa.Super.50, 51-55, 452 A.2d 1032, 1033-1034 (1982).

The lower court stated, *inter alia,* in its opinion in support of its decision, that it quashed 27 counts as

> . . .enough of an ambiguity existed in the definition of an 'office visit' before the January 1, 1983 revision [of the Medicaid Department's Fee Schedule] so as to create a reasonable basis for

misinterpretation of the term 'office visit' prior to the issuance of the revised definition . . .

We agree with appellant that any ambiguity or confusion as to appellant's interpretation of the Fee Schedule is more properly a matter relevant to appellee's defense which could be asserted at trial. However, we do not believe that an asserted ambiguity or confusion serves as a basis to quash facially valid informations. *Commonwealth v. Chew,* 338 Pa.Super. 472, 487 A.2d 1379 (1985); *Commonwealth v. Moser,* 328 Pa.Super. 237, 476 A.2d 980 (1984); *see also* Pa.R.Crim.P. 225, *Commonwealth v. Baranyai,* 278 Pa.Super. 83, 419 A.2d 1368 (1980).

We reject appellee's arguments that the lower court acted withing its discretion when it granted his motion in the nature of a petition for habeas corpus. Appellee entitled his petition before the lower court "Motion for Accelerated Rehabilitative Disposition and/or Motion to Strike Information." The lower court stated in its opinion that it treated this petition as a "Motion to Quash." Now appellee argues that his motion was "in the nature of a petition for habeas corpus." Appellee, having inartistically denominated his motion, should not now be permitted to advance a new theory as to its scope. Regardless of the appellation of this petition, however, we believe the lower court abused its discretion in dismissing these counts. It is true that a trial court has the authority to review evidence presented at a preliminary hearing to ascertain whether a *prima facie* case has been made out against a defendant. *Commonwealth v. Hess,* 489 Pa. 580, 414 A.2d 1043 (1980); *see also Commonwealth v. Ballard,* 501 Pa. 230, 460 A.2d 1091 (1983). This is true even where a petitioner's caption is incorrectly titled provided his intent is clear. *Commonwealth v. Hess, supra. See also Commonwealth v. Hetherington,* 460 Pa. 17, 331 A.2d 205 (1975). However, the

lower court is charged with the duty to examine the evidence with the limited inquiry as to whether there exists sufficient evidence to require a defendant to stand trial. *Commonwealth v. Ballard,* 501 Pa. at 233, 460 A.2d at 1092, *citing Commonwealth v. Hess, supra,* and *Commonwealth v. Krall,* 452 Pa. 215, 304 A.2d 488 (1973). *See also Commonwealth v. Hetherington, supra.* Our review of the record discloses that the Commonwealth presented the lower court with sufficient evidence, with respect to these counts, to meet the traditional threshold associated with this inquiry.[3] Therefore, we remand this case to the lower court for further proceedings consistent with this opinion.

Order reversed. Case remanded. Jurisdiction relinquished.

BECK, J., files a concurring statement.

BECK, Judge, concurring.

I concur in the majority's conclusion that the informations were not facially invalid, nor did they present any other defect that would prohibit prosecution. Therefore, the trial court erred in granting appellee's motion to quash.

However, I disagree with the majority's apparent consideration of appellee's argument that his motion below was in the nature of a petition for habeas corpus rather than a motion

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3. We disagree with the lower court's assertion that Procedure Code #90005 was subject " . . . to an ambiguous interpretation by a medical provider . . . . " An "office visit" under the Code is defined as "[an] office visit, brief examination, evaluation and/or treatment." We do not believe that the receipt of a phone call could reasonably be construed to meet the requirements of the Code's definition of an office visit.

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to quash. Appellee should not be permitted to change his theory as to the nature of his motion on appeal.

APPENDIX D — MEMORANDUM OPINION OF COURT OF COMMON PLEAS, PHILADELPHIA COUNTY DATED NOVEMBER 6, 1985

CP. 8312

Nos. 486, 487, 488

COMMONWEALTH OF PENNSYLVANIA

vs.

KENNETH A. STEIN

MEMORANDUM OPINION

Porter, J.

This case is before the Court upon the defendant's motion to quash[1] the Bills of Information lodged against him in accordance with Pa.R.C.P. 306, as amended, adopted June 30, 1964, effective January 1, 1965.

Defendant, a Podiatrist licensed by the Commonwealth of Pennsylvania, was indicted pursuant to the Medicaid Fraud Act of June 13, 1967, P.L. 31, § 1401 et seq; 62 Pa.S.A. 1401 (pocket part). Specifically defendant is charged with violations of Sec. 1407(a)(9), as to Information No. 0486, which provides it to be unlawful for a person to submit a claim for a service or item which was not rendered by the provider[2]; he is also charged with

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1. Defendant's motion is entitled "Motion to Strike"; however, it is treated here as a Motion to Quash.

2. Defendant is a "provider" under the Act as defined by Section 1401.

violations of Sec. 1407(a)(4), as to Information No. 0487, which declares it unlawful to submit a claim for services, supplies or equipment for which the provider has already received or claimed reimbursement from any source, and 1407(a)(1) as to Information No. 0488 which prohibits "knowingly and intentionally present(ing) for allowance or payment any false or fraudulent claim or cost report for furnishing services or merchandise under medical assistance, . . .".

For purposes of this motion, the parties[3] agree that defendant was a provider of medical services to persons who qualified for medical assistance under the Medical Assistance Program of the Department of Public Welfare of the Commonwealth of Pennsylvania. The program provides for payment to medical providers for services rendered to qualified recipients or medical assistance patients. The informations charge that defendant billed the Department of Public Welfare for services which in fact do not qualify for payments to the defendant as a medical provider. The Act defines a provider as ". . . any individual or medical facility which signs an agreement with the Department to participate in the medical assistance program, including but not limited to licensed practitioners, pharmacies, hospitals, nursing homes, clinics, home health agencies and medical purveyors."[4]

The disputed billings involved in this case were for renewals of prescriptions for orthopaedic shoes for the children of three qualified medical assistance recipients. The Commonwealth contends that the renewal of such prescriptions are not services

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3. Defendant is represented by Richard Max Bockol, Esq.; the Commonwealth is represented by Michael W. H. Duncan, Esq., a Deputy Attorney General.

4. 62 Pa.S.A. 1401, entitled "Definitions".

for which the provider is entitled to be paid because the preparation of prescriptions is not a service for which payments are authorized under the Department of Welfare's regulations and that the defendant in billing for office visits did not render services which must be rendered to be paid for an "office visit".

An office visit is defined in the Department's Fee Schedule (Procedure Code 90005) as: "office visit, brief examination, evaluation/and or treatment", for which the medical provider is entitled to be paid a $6.00 fee.[5] The Fee Schedule was revised, effective January 1, 1983, to include a "definitions" section which defined "visit" (i.e., office or home visit by a medical provider) as "a face-to-face encounter between a patient and practitioner, except as otherwise stated in the specific Medical Assistance provider chapters, for the purpose of furnishing medically necessary medical services." Accordingly, the effective definition of an office visit (the disputed services involved in this case) as of January 1, 1983 was a combination of the two definitions referred to, supra, so that an office visit which qualified for payment was defined as "a brief examination, evaluation and/or treatment of a patient", with whom the medical provider had a "face-to-face encounter".

Admittedly, the defendant did not have face-to-face encounters with the minor patients for whom he wrote renewal prescriptions in this case. Instead, defendant was contacted by members of the patients' families who stated the need for shoe prescriptions and when so requested, the defendant consulted the office file of the patient and wrote out the prescription requested. He then billed the Department of Welfare for an office visit under

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5. Fee Schedule, Medical Assistance Program, Dept. of Public Welfare, effective July 17, 1978.

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Fee Schedule, Procedure Code #90005.

It is argued by defendant that the Department's Fee Schedule - Procedure Code, was not sufficiently clear, nor sufficiently specific to put the defendant on notice that the services which he rendered to the patients in this case were not billable services under the said Fee Schedule - Procedure Code. He argues that since he did see or hear from members of the patients' families, evaluated the patients' needs from their files or charts and prepared the prescriptions that he did, in effect, perform "office visits". Defendant concedes (at least for purposes of this motion) that he did not see and examine the patients in question. The instant Bills of Information allege that defendant billed for thirty-three (33) "office visits" which were not qualified "office visits" as defined by the Fee Schedule - Procedure Code.

This court concludes that as to the alleged offenses involved in this case in which the events ("office visits") occurred before the "face-to-face encounter" definition of January 1, 1983, referred to supra, became effective, are not offenses for which the defendant should be put to trial, and accordingly as to those counts of Bills of Informations, defendant's Motion to Quash or Strike is granted. The court's reasoning as to this decision is that the Fee Schedule - Procedure Code was subject to an ambiguous interpretation by a medical provider before the "face-to-face encounter" requirement was promulgated, effective January 1, 1983. In this case, therefore, prior to January 1, 1983, the defendant did receive an office visit or office contact by members of the patients' families, he did examine the patients' file or chart, evaluate it and prescribe shoes for the patients' condition. Of course, it may be argued that the intent of the term "brief examination" means a brief examination of the patient (and not of the patient's file) and that the term "evaluation"

portends an evaluation of the patient and not an evaluation of his/her file. On the other hand, if only one interpretation could be gleaned from the pre-January 1, 1983 definition, there would have been no need to add the "face-to-face encounter" definition of "visit" by the January 1, 1983 Fee Schedule - Code Procedure. Therefore, this court is satisfied that enough of an ambiguity existed in the definition of "office visit" before the January 1, 1983 revision so as to create a reasonable basis for misinterpretation of the term "office visit" prior to the issuance of the revised definition of the term "visit".

Similarly, it is this court' s conclusion that as to those alleged offenses for which billings were made subsequent to January 1, 1983, defendant's position cannot prevail, and that his Motion to Quash those counts of the Bills of Information is, accordingly, denied.

The court is satisfied that the rules and regulations (or definitions) referred to herein were properly adopted in accordance with the Act, Section 1410, 62 Pa.S.A. 1410, and that Article XIV of the Medicaid Fraud Act, Section 1401 et seq., 62 Pa.S.A. 1401 et seq., is sufficiently clear so as to put medical providers on clear notice that billing the Department for non-billable services is a violation of the Act as set forth in Section 1407, 62 Pa.S.A. 1407, under which the instant Bills of Information are based. See *Fabio v. Civil Service Commission of the City of Philadelphia,* 414 A.2d 82, 489 Pa. 309, 9 A.L.R. 600 (1980); *Commonwealth v. Potts,* 460 A.2d 1127, 314 Pa.Super. 256 (1983).

Accordingly, the Court enters the following:

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ORDER

AND NOW, to wit, this 6th day of November, 1985, it is hereby ORDERED AND DECREED that the alleged offenses or counts involved in this case (Information Nos. 0486, 0487 and 0488, of December Term 1983) for which the defendant rendered services ("office visits") prior to January 1, 1983, are hereby quashed; and that defendant's motion to quash as to the alleged offenses or counts for which the defendant rendered services ("office visits") on or subsequent to January 1, 1983, is hereby denied.

Accordingly, defendant's motion to quash the Bills of Information (and the individual counts contained in the Bills of Information) is granted in part, and is denied in part.

BY THE COURT:

s/ Porter
J.

APPENDIX E — 10 PENNSYLVANIA BULLETIN 1985

DEPARTMENT OF PUBLIC WELFARE

[55 PA. CODE § 9417]

Podiatrists' Services; Outpatient Services

Notice is hereby given that the Department of Public Welfare, under the authority of the Public Welfare Code, act of June 13, 1967 (P.L. 31, No. 21) Article IV, §§ 403 and 443.3(2)(ii) as amended (62 P.S. §§ 403 and 443.3(2)(ii)), proposes to amend 55 Pa. Code § 9417 as set forth in Annex A to this notice.

An objective of the Department of Public Welfare is to improve podiatrists' services to the residents of the Commonwealth by establishing Medical Assistance fees more consistent with prevailing fees and to encourage more participation in the Program by podiatrists.

Therefore, the Department proposes to revise reference to the $6.00 fee for podiatrists for office visits, home visits, skilled nursing facility visists, or intermediate care facility visits in Medical Assistance Manual section 9417, Appendix I, Part II, Outpatient Services, Procedure Code Numbers 90005, 90110, 90300, and 90301 to reflect the increased fee of $8.00.

Funds for the increased fee to podiatrists have been provided in the Governor's 1980-81 budget.

These regulations were submitted to the Department of Aging on April 15, 1980 for comments pursuant to Act 1978-70.

Interested persons are invited to submit written comments, suggestions, or objections regarding the proposed regulations to

the Department of Public Welfare Room 510, Health and Welfare Building, Harrisburg, Pa. 17120, within 60 days after the date of publication of this notice in the *Pennsylvania Bulletin*. The public is also invited to review the comments submitted to the Department in Room 510 of the Health and Welfare Building.

Annex A

TITLE 55. PUBLIC WELFARE

DEPARTMENT OF PUBLIC WELFARE

PART III. MEDICAL ASSISTANCE

§ 9417—PODIATRIC SERVICES

APPENDIX I

I. General Provisions

* * *

II. Outpatient Services

Procedure Code	Terminology	Fee
90005	Office Visit, brief examination, evaluation and/or treatment	[$6.00] $8.00
90110	Home visit, brief examination, evaluation, and/or treatment NOTE: Payment will not be made for services for more than two persons during a visit to a patient's home, no matter how many others are seen.	[$6.00] $8.00

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90300 Skilled Nursing facility visit, brief examination.....
.....[$6.00] $8.00

90301 Intermediate Care facility visit, brief examination....
.....[$6.00] $8.00

90111 Home visit—additional fee for the first person seen in a patient's home or in a nursing facility during one call
..... $1.00

90113 Mileage—additional allowance for home, skilled nursing and intermediate care facility visits. No mileage allowance is paid for travel to any point in the city, borough, or unincorporated community in which the podiatrist's office is located. Mileage begins at the city, borough, or community limit. The County Assistance Office may define larger areas than the established limits within which mileage is not paid. When several patients in the same relative vicinity are visited on a continuous trip, the mileage allowed is for the call to the patient whose home is the most distant from the define limit of the community in which the podiatrist's office is located. Mileage is paid, beginning at the limits defined above, to the farthest destination and return at the rate of ten cents per mile.

* * *

[Pa. B. Doc. No. 80-751. Filed May 16, 1980, 9:00 a.m.]